

Muscle-bone interactions during fracture healing

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Abstract

Although it is generally accepted that the rate and strength of fracture healing is intimately linked to the integrity of surrounding soft tissues, the contribution of muscle has largely been viewed as a vascular supply for oxygen and nutrient exchange. However, more is becoming known about the cellular and paracrine contributions of muscle to the fracture healing process. Research has shown that muscle is capable of supplying osteoprogenitor cells in cases where the periosteum is insufficient, and the muscular osteoprogenitors possess similar osteogenic potential to those derived from the periosteum. Muscle's secretome includes proteins capable of inhibiting or enhancing osteogenesis and myogenesis following musculoskeletal injury and can be garnered for therapeutic use in patients with traumatic musculoskeletal injuries. In this review, we will highlight the current knowledge on muscle-bone interaction in the context of fracture healing as well as concisely present the current models to study such interactions.

Keywords: Muscle, Bone, Fracture, Mesenchymal Stem Cells, Paracrine

Introduction

In the orthopaedic field, the muscle-bone relationship is of utmost importance as surgeons must often battle increased complications, morbidity, and delayed fracture healing in cases with extensive soft tissue damage resulting from high energy trauma. The Gustilo-Anderson open fracture classification scale, which has been commonly used for nearly 4 decades, classifies severity almost solely on soft tissue (primarily muscle) injury, and the complication rate is much higher in fractures with soft tissue damage¹. Although it has long been accepted that intact surrounding soft tissues are important in the fracture healing process, the underlying mechanisms have not been fully elucidated. However, basic science and translational research have made advances in the understanding of how muscle injuries impede fracture healing.

To understand muscle's potential role in fracture repair, a comprehension of the repair process is necessary. In brief, fracture repair consists of three chronological and overlapping phases: a reactive phase, a reparative phase, and a remodeling phase. The reactive phase peaks within the first 24-48 hours and lasts less than 1 week. During this phase, endothelial damage to the vasculature causes a hematoma, drawing in inflammatory cells (lymphocytes, polymorphonuclear cells, monocytes) and fibroblasts to form granulation tissue². The granulation tissue is important for vascular ingrowth as well as the recruitment of mesenchymal stem cells (MSCs). The inflammatory cells release cytokines such as TNF- α , IL-1, IL-6, IL-11, and IL-18 to induce osteogenic differentiation of MSCs as well as promote angiogenesis³. The reparative phase begins within a few days after fracture and lasts several weeks. Pluripotent mesenchymal cells, dependent on local strain and oxygen tension, differentiate into fibroblasts, chondroblasts, or osteoblasts. Healing can occur through intramembranous ossification alone (direct healing) or a combination of intramembranous and endochondral ossification (indirect healing), depending on the degree of mechanical stability⁴. In endochondral ossification, a fibrocartilage callus forms and is subsequently replaced by a bony callus with woven bone deposition. In intramembranous ossification, lamellar bone regeneration occurs without the need for remodeling, but it requires stable fixation². Thus, the ossification process is dependent on

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the stability of the fracture site. During the remodeling phase, the woven bone is replaced with lamellar bone, and the bone is gradually remodeled under mechanical stress to its original contour. This phase can last for several years^{2,5}.

Vascularization and fracture healing

The importance of vascularization in osteogenesis cannot be overemphasized, as a nearby vascular supply is required for both normal development and bone regeneration⁶⁻⁹. Indeed, an early step in the fracture healing process is the formation of granulation tissue consisting of connective tissue and small blood vessels^{10,11}, reinforcing the importance of vascularization in healing. Surrounding soft tissues at the fracture site primarily have been considered an important vascular source¹² to deliver oxygen¹³, nutrients¹³, and potential osteoprogenitor cells to the injured area^{14,15}. In the surrounding soft tissue are MSCs and pericytes, which are crucial for angiogenesis in the wounded tissue^{16,17}. In the clinical arena, the rate of non-union is 4 times higher in cases with reduced vascular function¹⁸, and in animal fracture models that disrupt angiogenesis, bone formation is hindered through the suppression of osteoblast proliferation¹⁸⁻²⁰. Muscle flap coverage has been shown to increase bone blood flow and the rate of osteotomy union compared to skin tissue coverage, supporting the vascular role of muscle in bone regeneration²¹⁻²³.

Although vascularization has been shown to be critical for regeneration, there has been evidence of nearly equal vascularization in healed bone and non-unions in animal studies as well as in human patients^{20,24-26}. In a murine open tibial fracture model, Harry et al. observed faster fracture healing in musculocutaneous compared to fasciocutaneous flaps, despite the musculocutaneous flaps having decreased vascularization²⁷. These studies point to a more extensive role of muscle in the repair process than solely as a vascular supply.

Osteoprogenitors derived from muscle

The relationship between muscle and bone has been observed for decades and continues to be elucidated. Urist first deduced muscle's ability to induce bone formation in 1965 when decalcified bone implanted into muscle resulted in new bone formation^{28,29}. In fracture healing studies in multiple species, callus formation tends to be the largest and most dense at the interface between bone and muscle³⁰, suggesting that muscle contributes to callus formation or provides a suitable environment for its occurrence.

Muscle is also a common site for ectopic bone formation following physical trauma³¹, orthopaedic surgery³², or due to disease like fibrodysplasia ossificans progressiva, which has been identified to be a result of a mutation in a gene encoding a bone morphogenetic protein (BMP) receptor³³. BMPs, a group of growth factors involved in tissue architecture throughout the body, are of particular importance to bone formation as they induce osteoblast differentiation.

In the presence of BMPs, cells derived from muscle are ca-

pable of differentiating into cells expressing bone markers³⁴⁻³⁷. That muscle-derived cells capable of displaying osteogenic potential under proper conditions could partly explain the importance of muscle in fracture healing aside from their role in vascularization. In addition, muscle may be able to influence bone in a manner unlike any other tissue. When both muscle and fat are activated by exposure to a BMP-2 encoded adenovirus, the "gene-activated" muscle results in more consistent bone regeneration than the "gene-activated" fat³⁸. Furthermore, when muscle-derived stem cells (MDSCs) are recruited and driven to osteogenic differentiation by BMPs, they display an osteogenic potential that is equivalent to those derived from bone marrow³⁹. Lineage-traced MDSCs in a fracture healing model have been found to alter gene expression to give rise to chondrocytes, up-regulating chondrogenic markers Sox9 and Nkx3.2 and down-regulating the muscle marker Pax3³⁶. These studies provide evidence that, in the appropriate environmental conditions, muscle can supply osteoprogenitor cells required for the fracture repair process.

It should be noted, however, that MDSCs are not the sole osteoprogenitor cells derived from muscle. C2C12 myoblasts infected with a retroviral vector have been found to overexpress osteoactivin (OA) and transdifferentiate into osteoblasts and express bone-specific markers⁴⁰. Muscle-derived stromal cells, when administered TNF- α at low concentrations, are also capable of undergoing recruitment and osteogenic differentiation⁴¹. Muscle satellite cells were originally believed to be muscle stem cells restricted to the myogenic lineage⁴², but the osteogenic potential of these cells has been observed under several conditions. Satellite cell-derived myoblasts have been shown to differentiate into osteocytes following treatment with BMPs⁴³, into osteoblasts *in vivo* and *in vitro* in the presence of platelet-rich plasma⁴⁴, and the osteogenic potential of satellite cells can increase in response to cutaneous burn trauma⁴⁵. Satellite cells have been observed to express both myoblastic (Pax7, MyoD) and osteoblastic (alkaline phosphatase, Runx2) markers and are capable of differentiating into osteoblasts spontaneously⁴⁶.

The abundance of potential osteogenic cells derived from muscle could have applications in the future in tissue engineering techniques, particularly in cases where the bone marrow or periosteum is compromised. It has been commonly believed that in fractures in which the periosteum is intact, repair occurs largely through endochondral ossification driven by a periosteal supply of cells^{10,47-50}. Indeed, in open fractures with a stripped periosteum, Liu et al. found that myogenic cells of the MyoD-lineage contributed to fracture repair, but MyoD-expressing cells were not incorporated into the callus in the case of a closed fracture with intact periosteum⁵¹. Such a study demonstrates that myogenic cells can be activated to serve as a secondary supply of cells when the periosteal supply becomes compromised^{52,53}. These recent findings of muscle's ability to augment the periosteal supply of osteoprogenitor cells provide insight into the clinical observations of prolonged recovery time and increased morbidity that is especially seen associated with high energy fractures with substantial soft tissue damage.

Muscle-bone paracrine interactions in bone repair

Only within the past two decades has the muscle secretome been identified and explored. With the recent advent of improved characterization instruments, the muscle secretome has rapidly expanded to over 200 proteins⁵⁴. Muscle secreted proteins important in muscle-bone interactions include, but are not limited to: myostatin, BMPs, secreted protein acidic and rich in cysteine (SPARC or osteonectin), interleukin (IL)-1, IL-4, IL-6, tumor necrosis factor (TNF) α , and insulin-like growth factor (IGF)-1^{41,54-56}. Many of the muscle derived factors have previously been described to play a role in muscle-bone interactions without addressing the interactions specifically during fracture repair. Importantly, the presence of inflammation differentiates fracture repair from bone formation during development. That is, fracture healing is initiated by an inflammatory cascade, which is mediated by a number of factors, including but not limited to: neutrophils, macrophages, lymphocytes, and various inflammatory cytokines (i.e., IL-1, IL-6, TNF α)^{2,57-59}. Mounting and maintaining an appropriate inflammatory response in early fracture healing is critical for adequate repair and multiple studies have demonstrated that interference with the inflammatory process can either impair^{60,61} or improve⁶² fracture healing. This review focuses primarily on four factors known to be involved in muscular injury and fracture repair and are therefore likely to contribute to muscle-bone interactions in the presence of inflammation.

Insulin-like growth factor-1

IGF-1 is recognized as a key myokine that may direct local fracture healing⁶³. IGF-1 is expressed by maturing osteoblasts in culture⁶⁴ and expression has been localized using *in situ* hybridization to osteoblasts during phases of matrix formation and remodeling in fractured human bone⁶⁵. Further signifying the importance of IGF-1 to fracture healing, delivery of IGF-1 to ovine bone defects promotes accelerated bone formation^{66,67}. The association of low systemic levels of IGF-1 with osteoporosis^{68,69} suggests that local production of IGF-1 by nearby skeletal muscle tissue may support bone healing. Given that skeletal muscle up-regulates expression of IGF-1 in response to injury⁷⁰⁻⁷², the context of fractures involving muscle trauma specifically highlight this possibility. Overexpression of IGF-1 in skeletal muscle can result in increased systemic concentrations evidencing the capacity of skeletal muscle as a paracrine organ to support nearby bone healing⁷³. IGF-1 plays a role in muscle fiber repair and regenerative processes via a number of mechanisms to include increasing protein synthesis via PI3-AKT-mTOR pathway and by activating and promoting proliferation of satellite cells^{74,75}. Perhaps most interesting in the context of complex musculoskeletal injury is the anti-inflammatory (i.e., inhibition of NF- κ B) role of IGF-1 in muscle^{76,77} and bone⁶⁷.

Myostatin

Perhaps the most well-known muscle derived protein, myostatin, has been implicated to play a significant, albeit inhibitory, role in fracture repair. Myostatin is a member of the TGF- β superfamily, negatively regulating muscle growth, development, and regeneration^{78,79}. Its negative trophic influence has been supported in myostatin null mice that demonstrate increased bone strength and increased bone mineral density⁸⁰⁻⁸². Furthermore, myostatin inhibition by decoy receptors increases musculoskeletal mass⁸³. Interestingly however, expression of myostatin is elevated with significant musculoskeletal injury, specifically in the early part of bone repair^{84,85}. Due to its negative role in musculoskeletal development, interventions were targeted toward inhibiting myostatin after skeletal injury. Small molecule inhibition of myostatin following orthopaedic trauma has been demonstrated to improve muscle regeneration and fracture healing^{79,85,86}. These data suggest that inhibition of myostatin may be a plausible intervention to improve fracture healing outcomes in patients with significant musculoskeletal injuries. However, the conundrum of elevated myostatin after musculoskeletal injury remains poorly understood.

Bone morphogenetic proteins

Generally speaking, BMPs are growth factors for various skeletal tissues and are required for skeletal development. Conditional knockout mice deficient in BMPs displayed a wide range of skeletal defects^{87,88}. There are 7 members of the BMP family, of which BMPs 2-7 belong to the TGF β superfamily⁸⁹. Multiple BMPs have been demonstrated to promote osteoblastic differentiation of bone marrow stromal cells^{90,91}. Specifically, BMP-2 and BMP-7 are FDA approved for use in clinical musculoskeletal therapeutics due to their role in osteoblast differentiation and musculoskeletal repair. Unfortunately, concerns have arisen regarding the multiple side effects and off-label usage of BMPs including a recent link to oncogenic side effects with use of BMP-2^{92,93}. More novel approaches to utilization of BMP-2 in fracture healing includes modified muscle cells that secrete BMP-2. Critical size rat femoral defects underwent quicker bridging and restored mechanical strength when receiving activated muscle secreted BMP-2³⁸. Though not a member of the TGF β superfamily and not used in the clinical setting currently, BMP-1 is secreted by muscle and may play a role in fracture healing. BMP-1, specifically, is a protease secreted by muscle that cleaves procollagen⁹⁴. In patients with traumatic blast injuries, both BMP-1 protein and mRNA levels were elevated⁹⁵, suggesting a significant role for BMP-1 in musculoskeletal repair. Therefore, better understanding of the roles of muscle derived BMPs in skeletal tissue regeneration is warranted to improve musculoskeletal repair in patients who suffer extensive traumatic injuries.

SPARC or osteonectin

Osteonectin is a phosphorylated glycoprotein present in developing bone in many animal species⁹⁶. Osteonectin is suggested to serve multiple functions in the developing bone

matrix, including collagen organization, osteoblast growth and proliferation, and matrix mineralization⁹⁷. Mice deficient in osteonectin display osteopenia and decreased bone mineral content⁹⁸. Importantly, osteonectin is secreted by injured and regenerating myotubes and muscle fibers⁹⁹. Osteonectin expression by these sources is dependent on injury severity, suggesting that more severe musculoskeletal injuries result in greater osteonectin expression⁹⁹. Longitudinal studies of fracture healing show detectable osteonectin transcripts throughout the healing phase^{100,101}, most notably from days 9 to 15¹⁰². These studies provide evidence for the significant role osteonectin plays in bone regeneration and suggest muscle may be a source of osteonectin during musculoskeletal repair.

Mechanical muscle-bone interactions

It would be remiss to forego some discussion of the mechanical influences involved in muscle bone interactions. The cellular mechanisms by which mechanical strain affects bone are largely uncharacterized, but some data suggest it is due in part to gap junctions in bone formed by connexin43^{103,104}. Though characterization of mechanically induced cellular mechanisms remains limited, multiple studies have pointed to the importance of muscle's mechanical interactions on bone health¹⁰⁵. Disuse atrophy via denervation or immobilization has been shown to decrease bone integrity in animal models¹⁰⁶⁻¹⁰⁸. Furthermore, multiple studies have demonstrated that muscle paralysis induced by administration of botulinum toxin impairs bone quality and/or fracture healing¹⁰⁹⁻¹¹³. Further research into the cellular mechanisms of the mechanical influence of muscle is warranted to better understand how bone can be further modified by muscle during the healing process.

Muscle in fracture healing - current models

Murine

Multiple murine studies have been conducted to examine the extent to which muscle enhances bone repair after significant musculoskeletal injury. Zacks and Sheff¹¹⁴ conducted early sentinel research addressing the potential for muscle to contribute to bone regeneration in 1982. Zacks and Sheff utilized experimental groups where after limb muscle resection, isotopic or heterotopic minced muscle implants were placed immediately adjacent to the periosteum. Their control groups consisted of liver minced implant or no implant. They concluded that isotopic and heterotopic minced muscle preparations implanted adjacent to the periosteum could directly induce new bone formation *in situ* as demonstrated by the formation of exostoses and metaplastic nodules in the minced muscle implants¹¹⁴. The work of Zacks and Sheff confirmed the importance of studying the trophic influence of muscle on bone.

As previously mentioned, Harry et al. conducted a murine study addressing the importance of muscle in open tibial fracture repair²⁷. The authors demonstrated that musculocutaneous flaps performed superior to the fasciocutaneous flaps, though the fasciocutaneous flaps provided more angiogenic capacity. There-

fore, the osteogenic capability of muscle is greater than that of cutaneous flaps and extends beyond simply angiogenesis.

Rattus

Multiple studies have also been conducted utilizing rat models to assess bone healing in light of soft tissue injuries. A study by Hao et al.¹⁰⁹ evaluated the effect of muscle atrophy and paralysis on femoral fracture healing. Atrophy of the quadriceps muscle, induced by administration of botulinum A toxin, negatively impacted the healing capacity of femoral fractures in rats. Utvag et al. conducted three critical studies¹¹⁵⁻¹¹⁷ assessing the role of periosteum or surrounding soft tissue in bone healing. In 1998 Utvag et al.¹¹⁵ demonstrated that fracture healing was impaired when periosteal tissue was mechanically removed from interacting with surrounding muscle. Additionally, Utvag et al. showed that significant muscle injury and absence of muscle by resection, or by traumatic injury in the clinical setting, significantly compromised the regeneration potential of non-augmented healing bone^{116,117}. The importance of muscle for bone healing was further confirmed by the work of Willett et al. that demonstrated that volumetric muscle loss (VML) also impairs the effectiveness of BMP-2 in the healing of a critical size bone defect¹¹⁸. Taken together, it is clear that frank loss of muscle tissue (VML) is a significant comorbidity to poor bone healing outcomes.

Humans

Since the mid 1970s, open fractures have been graded clinically according to the Gustilo-Anderson classification scale^{1,119}, which is largely based on the severity of soft tissue injury associated with open fractures. Gustilo and Anderson identified 3 types of fractures: Type I - open fracture with a wound <1 cm and clean; Type 2 - open fracture with a wound >1 cm without extensive soft tissue damage; and Type 3 - open fracture with extensive soft tissue damage¹¹⁹. Type 3 fractures were later subdivided into 3 subcategories¹. The Gustilo Anderson classification makes it evident that soft tissue injury plays a significant role in the musculoskeletal repair process in the clinical setting. Specifically, open fractures (Type 3) with extensive soft tissue injury demonstrate greater complication rates than open fractures without soft tissue injury (Types 2 & 3)^{120,121}.

Similar to the results observed from animal studies, substantial clinical data exist characterizing the importance of muscle integrity in bone repair. A multitude of studies have demonstrated soft tissue damage associated with fractures impairs the ability of bone to repair properly^{122,123}, while the quality of the muscle bed is essential for appropriate bone formation and bone healing^{30,51}.

Similar to the murine study conducted by Harry et al.²⁷, Gopal et al.¹²⁴ specifically examined the treatment of open tibial fractures with fasciocutaneous flaps versus muscle flaps in humans. The results of their study were then later confirmed by Harry et al. in the mouse model, with both groups concluding that muscle flaps are superior in bone healing. Even in clinical

practice, the gold standard of treating critical size defects or extensive fractures includes soft tissue coverage, supporting the significance of muscle-bone interactions during bone healing.

A more recent meta-analysis by Reverte et al.¹²⁵ analyzed 16 studies addressing the union rate and time to fracture union in patients with tibial fractures and associated compartment syndromes. Reverte et al. demonstrated that tibial fractures with associated soft tissue injury significantly impaired fracture healing. The rate of delayed union or non-union in tibial fractures with associated compartment syndrome was 55% compared to only 18% in patients with tibial fracture without associated compartment syndrome¹²⁵. This study points to the importance of soft tissue integrity in the quality of fracture healing.

Conclusion

Taken together, these studies illustrate the importance of muscle-bone interactions in bone regeneration. Exact mechanisms by which muscle is responsible for bone formation in the healing process are not well elucidated. Most of the current literature is limited to qualitative findings of muscle's role in bone healing. Therefore, more rigorous models with aims directed toward identification and quantification of muscle-derived effectors of bone regeneration are required. Identifying and characterizing the muscle-derived factors responsible for bone healing may provide opportunities to develop therapies to augment normal physiologic mechanisms underlying bone regeneration.

Current strategies, such as the use of BMPs, in fracture healing have recently been thought of as having more limited benefit due to the more robust understanding of detrimental side effects. This review outlines some potential targets for therapeutic development, including stimulation of MDSCs, inhibition of myostatin, or administering or enhancing the targeted expression of osteonectin. Future studies addressing muscle factors associated with bone healing may provide insight into these mechanisms necessary to promote bone regeneration. Soft tissue integrity is crucial to appropriate bone regeneration, but our understanding of the mechanisms is limited at the present time. A better understanding of muscle's effect on fracture healing at the cellular and molecular levels will open translational opportunities to incorporate the findings into clinics and operating rooms abroad.

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